|  |  |  |  |
| --- | --- | --- | --- |
| Child’s Full Name | | | Today’s Date |
| **CONTACT INFORMATION** | | | |
| Parent’s/Guardian’s Name | | | Telephone |
| Parent’s/Guardian’s Name | | | Telephone |
| Primary Health Care Provider | | | Telephone |
| Specialist (if applicable) | | | Telephone |
| Specialist (if applicable) | | | Telephone |
| **CHILD’S SPECIAL NEEDS** | | | |
| Diagnosis, if known: | | | |
| Known symptoms and triggers: | | | |
| Describe activity, behavioral, or environmental modifications that are needed for the child: | | | |
| Allergies (other than food allergy): | | | |
| For food allergies or special dietary needs due to a health condition - must obtain written instructions from child’s health care provider (use page 3 of this form or health care provider’s form) | | | |
| **MEDICATIONS *(Medication Authorization Form must be completed for each medication.)*** | | | |
| List medication to be given at **scheduled times**, and how medication is to be given. | | | |
| List medication to be given during an **emergency**, and how medication is to be given.    Describe symptoms that would trigger emergency medication. | | | |
| **EMERGENCY RESPONSE PLAN** | | | |
| List the steps and procedures the early learning or school-age provider should perform during an emergency related to your child’s special need. | | | |
| **SUGGESTED TRAINING FOR STAFF** | | | |
| List suggested special skills training/education for the early learning or school-age program staff. | | | |
| **SUPPORTING DOCUMENTATION** | | | |
| Please attach supporting documentation to this Individual Care Plan, including any existing individual educational plan (IEP), individual health plan (IHP), 504 plan, or individualized family service plan (IFSP). WAC 110-300-0300 and 110-301-0300 requires an early learning or school-age provider to have supporting documentation of the child’s special needs provided by the child’s licensed or certified:   1. Physician or physician’s assistant 2. Mental health professional 3. Educational professional 4. Social worker with a bachelor’s degree or higher with a specialization in the individual child’s needs; or 5. Registered nurse or advanced registered nurse practitioner. | | | |
| **SIGNATURES** | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent or Guardian Signature  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Early Learning or School-Age Provider Signature  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health Care Provider Signature  *(recommended)* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | | |
|  |  | | |
| **This section to be completed by child’s parent or guardian, if applicable:**  *I hereby give permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to provide*  (name of visiting health professional or specialist)  *services to my child at this early learning or school-age program.* | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent or Guardian Signature | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | |

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| **FOOD ALLERGY and/or SPECIAL DIETARY REQUIREMENTS** | | | |
| This page must be completed and signed by the child’s health care provider and parent or guardian. | | | |
|  | | | |
| Child’s Full Name: | | | Today’s Date: |
| Food the child must not consume  (list each food separately) | Appropriate substitute food(s) | | |
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|  |  | | |
| Describe allergic reactions and symptoms associated with this child’s particular allergies. | | | |
| Describe the treatment plan for the early learning or school-age provider to follow in response to child’s allergic reaction (include names of medication, dosage amount, and directions for how to administer medication). | | | |
| Other special dietary requirements due to a health condition. | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Health Care Provider Signature | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent or Guardian Signature | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date | |